

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11426

CERTIFICATE OF DEATH

11415

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 3 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RAYMOND ROSCOE COSTLEY		4. DATE OF DEATH Month Day Year NOV. 9, 1956	
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-1-1921
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman (steam)		10b. KIND OF BUSINESS OR INDUSTRY Henryton Hosp.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Raymaond I. Costley		14. MOTHER'S MAIDEN NAME Alverta Myers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes W.W.11		16. SOCIAL SECURITY NO. 214-16-7415	
17. INFORMANT Mrs. Pauletta Costley, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC Arrest, Carinoma of lung, cerebral 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastasis, Anemia, malnutrition- DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH MARCH 56 TO NOV 56	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 56 , to 9 Nov , 19 56 , that I last saw the deceased alive on 9 Nov , 19 56 , and that death occurred at 9:15 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Howard E. Hall M.D. Agnew Nov 9, 1956 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Howard E. Hall			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-12-1956	
22c. NAME OF CEMETERY OR CREMATORY Fairview		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Maryland	
24a. REC'D BY REGISTRAR DATE 11-13-1956		24b. REGISTRAR'S SIGNATURE H. H. Hedrick	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

See How to Fill Out This Certificate

<p>1. Name of Deceased [REDACTED]</p>		<p>2. Sex [REDACTED]</p>		<p>3. Race [REDACTED]</p>	
<p>4. Date of Birth [REDACTED]</p>		<p>5. Date of Death [REDACTED]</p>		<p>6. Place of Birth [REDACTED]</p>	
<p>7. Usual Residence [REDACTED]</p>		<p>8. Cause of Death [REDACTED]</p>		<p>9. Manner of Death [REDACTED]</p>	
<p>10. Signature of Physician [REDACTED]</p>		<p>11. Signature of Registrar [REDACTED]</p>		<p>12. Date of Registration [REDACTED]</p>	

RECEIVED
 NOV 13 1956
 BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

. 11427 CERTIFICATE OF DEATH

11416

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poplar Springs		c. LENGTH OF STAY IN 1b 28 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poplar Springs		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. Mt. Airy			d. STREET ADDRESS R.D. Mt. Airy		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HILDA Middle VIRGINIA Last ECKER			4. DATE OF DEATH Month NOV. Day 2, Year 1956		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-18-1907		9. AGE (In years last birthday) 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Charles Bussard			14. MOTHER'S MAIDEN NAME Clara J. Baker		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT Address Claude I. Ecker, same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple sclerosis 345X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 7 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from June 15 , 19 56 , to November 2 , 19 56 , that I last saw the deceased alive on November 2 , 19 56 , and that death occurred at 4 P.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE James P. Kerr		M.D. Homascus, Md.		DATE SIGNED 11-2-56	
PHYSICIAN'S NAME (Type) JAMES P. KERR					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-5-1956		22c. NAME OF CEMETERY OR CREMATORY Poplar Springs	
22d. LOCATION (City, town, or county) Howard Co., Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Maryland		24a. REC'D BY REGISTRAR DATE NOV 5 1956	
24b. REGISTRAR'S SIGNATURE H. J. Schuch					

1 11428 11412 Reg. Dist. No.

11428 CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poplar Springs				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First 7/ORA Middle A Last 7LEMING				4. DATE OF DEATH Month NOV Day 10 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/19/1886		9. AGE (In years last birthday) yrs. 70	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John J. Fleming				14. MOTHER'S MAIDEN NAME Hannah A. Driver			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT George D. Fleming Address R.D.#2 MT. Airy			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC Arrest, CARCINOMA COLON, 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) LIVER metastasis to BONE, LUNGS, CEREBRAL DUE TO (c) ALCA- ANEMIA.						INTERVAL BETWEEN ONSET AND DEATH 1955 to NOV 1956	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 1955 , 19____, to NOV 10 , 19 56 , that I last saw the deceased alive on 10 NOV 1956 , and that death occurred at 7:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Applawick, Md DATE SIGNED 10 Nov 56							
ACTUAL SIGNATURE Howard E. Hall M.D.				PHYSICIAN'S NAME (Type) Howard E. Hall			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-13-1956		22c. NAME OF CEMETERY OR CREMATORY Morgan Chapel		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, ADDRESS Winfield, Maryland				24a. REC'D BY REGISTRAR NOV 14 1956		24b. REGISTRAR'S SIGNATURE Alice Kelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11429 CERTIFICATE OF DEATH

11418

Reg. Dist. No. 191

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Montgomery Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle GOINS Last				4. DATE OF DEATH Month November Day 8 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1880		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Coal Miner		11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Williams Goins				14. MOTHER'S MAIDEN NAME Mandy Maxie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 223-16-2597		17. INFORMANT Frona Goins, Ellicott City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Hemorrhage DUE TO Hypertension (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 days							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 nov. , 19 56 , to 8 nov. , 19 56 , that I last saw the deceased alive on 8 nov. , 19 56 , and that death occurred at 5:45 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) main st Ellicott Md DATE SIGNED Nov 9 1956							
ACTUAL SIGNATURE George E Groleau		PHYSICIAN'S NAME (Type) GEORGE E. GROLEAU					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-14-1956		22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md.				24a. REC'D BY REGISTRAR NOV 13 1956		24b. REGISTRAR'S SIGNATURE J.C. Laughery	

Page 10

BUREAU V. S.

NOV 13 1956

RECEIVED

— 1 —

11430 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Howard</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Howard</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - West Friendship</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - West Friendship</i>			
c. LENGTH OF STAY IN 1b <i>Life</i>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Isabelle E. Grimes</i>				4. DATE OF DEATH Month <i>Nov</i> Day <i>11</i> Year <i>1956</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-10-1879</i>	9. AGE (In years last birthday) <i>77</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Scirenow</i>				14. MOTHER'S MAIDEN NAME <i>Melina Gaither</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT Address <i>Mrs. Harry Cape - West Friendship, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 ACUTE CARDIAC FAILURE</i> DUE TO (b) <i>VENTRICULAR FIBRILLATION</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>CORONARY ARTERY DISEASE</i>				INTERVAL BETWEEN ONSET AND DEATH <i>5 MINS</i> <i>5 MINS</i> <i>20 YRS</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>July</i> , 19 <i>47</i> , to <i>Nov 11</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Nov 11</i> , 19 <i>56</i> , and that death occurred at <i>8:30 AM</i> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <i>Charles S. Whitaker</i> M.D.				<i>CLARKSVILLE, MD. 11-11-56</i>			
PHYSICIAN'S NAME (Type)				<i>CHARLES S. WHITAKER, M.D., CLARKSVILLE, MD.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>11-14-56</i>		<i>Oak Grove</i>		<i>Shawwood, Howard, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<i>Arthur W. Haight, Hyattsville, Md.</i>				<i>NOV 15 1956</i>		<i>Alvin H. H.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1950 CERTIFICATE OF DEATH

Page One of

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
JAMES A. BROWN		M		45		1905		BALTIMORE		BALTIMORE		MD		USA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HEIGHT		WEIGHT	
Carpenter		High School		Married		Catholic		White		White		5'8"		175	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
Heart Disease		Natural		3 weeks		11/15/56		11:00 AM		Home		BALTIMORE		MD	
SIGNS AND SYMPTOMS		PREVIOUS ILLNESS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY		HABITS		DIET	
Chest pain, shortness of breath		None		None		None		None		None		None		None	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CITY OF DEATH		STATE OF DEATH	
11/15/56		11:00 AM		Home		BALTIMORE		MD		USA		BALTIMORE		MD	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. A. Smith		J. B. Jones		J. C. Brown		J. D. Green		J. E. White		J. F. Black		J. G. Gray		J. H. Blue	

BUREAU V. S.

NOV 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11431 CERTIFICATE OF DEATH

Reg. Dist. No.

11420/95

1. PLACE OF DEATH o. COUNTY <u>Harward</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Harward</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>High Ridge Laurel</u>	c. LENGTH OF STAY IN 1b <u>11 mos</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>High Ridge Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Blanche Elizabeth Hall</u>		4. DATE OF DEATH <u>Nov 5 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 17, 1891</u>
9. AGE (In years last birthday) <u>65 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>La Plata, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Edward Garner</u>		14. MOTHER'S MAIDEN NAME <u>Miller Welch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Richard A. Hall</u>		Address <u>Laurel Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-Vas. Disease</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Insuff.</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>2 wks</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 19, 1954</u> to <u>Nov. 5, 1956</u> , that I last saw the deceased alive on <u>Nov. 4, 1956</u> , and that death occurred at <u>7 a. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank E. Shipley</u> M.D.		ADDRESS (Street, city or town, state) <u>Savage, Md.</u> DATE SIGNED <u>11/5/56</u>	
PHYSICIAN'S NAME (Type) <u>Frank E. Shipley, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>Burial</u>		<u>11/7/56</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>St Marys Cem.</u>		<u>Laurel Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>16 With Road, Laurel Md</u>		<u>Laurel Md</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>NOV 20 1956</u>		<u>A. H. Hedrich</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. MARRIAGE DATE		8. OCCUPATION		9. CAUSE OF DEATH		10. PLACE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	

11432 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hydenville</u>		c. LENGTH OF STAY IN 1b <u>50 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Hydenville</u>	
3. NAME OF DECEASED (Type or print) <u>Hamilton Arthur Hawkins</u>		4. DATE OF DEATH <u>Nov. 6 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25, 1881</u>
9. AGE (In years last birthday) <u>74 yrs.</u>		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Track Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O. R. R.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James M. Hawkins</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Hawkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>705-09-0196</u>	
17. INFORMANT <u>Ms. Carrie E. Hawkins - Hydenville</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arterio-sclerosis</u> DUE TO <u>Obesity</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>35 min.</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-21</u> , 19 <u>56</u> , to <u>11-6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-15</u> , 19 <u>56</u> , and that death occurred at <u>8:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bertrand R. Gau</u>		ADDRESS (Street, city or town, state) <u>Central Avenue, Sykesville, Md.</u>	
DATE SIGNED <u>11-6-56</u>			
PHYSICIAN'S NAME (Type) <u>Bertrand R. GAU</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-9-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		22d. LOCATION (City, town, or county) (State) <u>Hydenville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight - Sykesville, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>DATE 9 1956</u>		24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF CLERK</p>		<p>16. SIGNATURE OF REGISTRAR</p>	

BUREAU OF HEALTH

NOV 9 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

11433

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11422

Reg. Dist. No.

190

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Howard				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups Rural		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Off Rt. 32 near Berger Road				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last PAUL E KESTERSON				4. DATE OF DEATH Month Day Year Nov. 14, 1956				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 13, 1880		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Bay Pilot		11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Thomas E. Kesterson				14. MOTHER'S MAIDEN NAME Mary E. Adams				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address T. Ellis Kesterson, Baltimore 6, Md				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Partial Cremation in burning house trailer DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Burned in house trailer						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Residence		20f. (City or town) (County) (State) Jessups (rural) Howard Md		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>George E. Burgtorf</i> EXAMINER'S NAME (Type) George E. Burgtorf M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 11-14-56		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-16-56		22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Md		
23. FUNERAL DIRECTOR'S SIGNATURE F. C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE NOV 19 1956		24b. REGISTRAR'S SIGNATURE <i>E. Bird Williams</i>		

STATE OF MARYLAND
DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John J. Jones		Male		45		Nov. 1, 1956	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural	
Occupation		Education		Previous Illnesses		Drugs Taken	
Engineer		High School		Hypertension		None	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Examination		Time of Examination		Place of Examination		Witnesses	
Nov. 1, 1956		10:00 AM		Baltimore, Md.		[Signatures]	

RECEIVED
NOV 19 1956
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11434

CERTIFICATE OF DEATH

11423/94
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HOWARD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FULTON (RURAL)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SIMONS NURSING HOME</u>				d. STREET ADDRESS <u>4621 ROSEDALE AVE.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>JEANNETTE B. KIDD</u>				4. DATE OF DEATH Month Day Year <u>NOV. 28, 1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>OCT 10, 1901</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>US Govt GAO</u>		11. BIRTHPLACE (State or foreign country) <u>HOMESDALE, PA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JOHN L. BAUMAN</u>				14. MOTHER'S MAIDEN NAME <u>CHRISTINE C. UNVERVAUT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>5735-144 ST. N.W. D.C.</u>		17. INFORMANT Address <u>JOHN M. KIDD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> 083.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Post encephalitic Parkinsonism</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>13 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 30, 1955</u> , to <u>Nov. 28, 1956</u> , that I last saw the deceased alive on <u>Nov 28, 1956</u> , and that death occurred at <u>6:00 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>CLARKSVILLE, MARYLAND</u> DATE SIGNED <u>11/28/56</u>							
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.							
PHYSICIAN'S NAME (Type) <u>CHARLES S. WHITAKER, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 30, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mark's Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fairfax, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walter</u> ADDRESS <u>254 Carroll Dr NW DC</u>				24a. REC'D BY REGISTRAR <u>DEC 3 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Maria Hutches</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 3 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11435 CERTIFICATE OF DEATH

11424

Reg. Dist. No. 191

1. PLACE OF DEATH a. COUNTY <u>HOWARD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>HOWARD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(RURAL) Ellicott City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Ave.</u>		d. STREET ADDRESS <u>College Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>THOMAS STANLEY MARTIN</u>		4. DATE OF DEATH <u>Nov. 24, 1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>UNKNOWN</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>JANITOR</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ANDREW MARTIN</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE HEALEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-14-9483</u>	
17. INFORMANT <u>MRS. ANNIE R. MARTIN</u>		Address <u>College Ave. Ellicott City, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>alcoholism, acute.</u> 322.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>Alcoholism, Chronic.</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 4, 1950</u> , to <u>Nov. 24, 1956</u> , that I last saw the deceased alive on <u>Nov. 24, 1956</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William F. Gassaway</u>		ADDRESS (Street, city or town, state) <u>Ellicott City, Md.</u>	
PHYSICIAN'S NAME (Type) <u>William F. Gassaway M. D.</u>		DATE SIGNED <u>11/24/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/27/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Ellicott City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Sons, Catonsville 28, Md.</u>		24a. REC'D BY REGISTRAR <u>John A. Loughran, Jr.</u>	
24b. REGISTRAR'S SIGNATURE <u>B. C. L.</u>		DATE <u>Nov. 27, 56</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF DECEASED</p>		<p>12. SIGNATURE OF WITNESSES</p>	
<p>13. SIGNATURE OF PHYSICIAN</p>		<p>14. SIGNATURE OF CORONER</p>	
<p>15. SIGNATURE OF JUDGE</p>		<p>16. SIGNATURE OF CLERK</p>	
<p>17. SIGNATURE OF NOTARY</p>		<p>18. SIGNATURE OF REGISTRAR</p>	
<p>19. SIGNATURE OF DECEASED</p>		<p>20. SIGNATURE OF WITNESSES</p>	
<p>21. SIGNATURE OF PHYSICIAN</p>		<p>22. SIGNATURE OF CORONER</p>	
<p>23. SIGNATURE OF JUDGE</p>		<p>24. SIGNATURE OF CLERK</p>	
<p>25. SIGNATURE OF NOTARY</p>		<p>26. SIGNATURE OF REGISTRAR</p>	
<p>27. SIGNATURE OF DECEASED</p>		<p>28. SIGNATURE OF WITNESSES</p>	
<p>29. SIGNATURE OF PHYSICIAN</p>		<p>30. SIGNATURE OF CORONER</p>	
<p>31. SIGNATURE OF JUDGE</p>		<p>32. SIGNATURE OF CLERK</p>	
<p>33. SIGNATURE OF NOTARY</p>		<p>34. SIGNATURE OF REGISTRAR</p>	
<p>35. SIGNATURE OF DECEASED</p>		<p>36. SIGNATURE OF WITNESSES</p>	
<p>37. SIGNATURE OF PHYSICIAN</p>		<p>38. SIGNATURE OF CORONER</p>	
<p>39. SIGNATURE OF JUDGE</p>		<p>40. SIGNATURE OF CLERK</p>	
<p>41. SIGNATURE OF NOTARY</p>		<p>42. SIGNATURE OF REGISTRAR</p>	
<p>43. SIGNATURE OF DECEASED</p>		<p>44. SIGNATURE OF WITNESSES</p>	
<p>45. SIGNATURE OF PHYSICIAN</p>		<p>46. SIGNATURE OF CORONER</p>	
<p>47. SIGNATURE OF JUDGE</p>		<p>48. SIGNATURE OF CLERK</p>	
<p>49. SIGNATURE OF NOTARY</p>		<p>50. SIGNATURE OF REGISTRAR</p>	
<p>51. SIGNATURE OF DECEASED</p>		<p>52. SIGNATURE OF WITNESSES</p>	
<p>53. SIGNATURE OF PHYSICIAN</p>		<p>54. SIGNATURE OF CORONER</p>	
<p>55. SIGNATURE OF JUDGE</p>		<p>56. SIGNATURE OF CLERK</p>	
<p>57. SIGNATURE OF NOTARY</p>		<p>58. SIGNATURE OF REGISTRAR</p>	
<p>59. SIGNATURE OF DECEASED</p>		<p>60. SIGNATURE OF WITNESSES</p>	
<p>61. SIGNATURE OF PHYSICIAN</p>		<p>62. SIGNATURE OF CORONER</p>	
<p>63. SIGNATURE OF JUDGE</p>		<p>64. SIGNATURE OF CLERK</p>	
<p>65. SIGNATURE OF NOTARY</p>		<p>66. SIGNATURE OF REGISTRAR</p>	
<p>67. SIGNATURE OF DECEASED</p>		<p>68. SIGNATURE OF WITNESSES</p>	
<p>69. SIGNATURE OF PHYSICIAN</p>		<p>70. SIGNATURE OF CORONER</p>	
<p>71. SIGNATURE OF JUDGE</p>		<p>72. SIGNATURE OF CLERK</p>	
<p>73. SIGNATURE OF NOTARY</p>		<p>74. SIGNATURE OF REGISTRAR</p>	
<p>75. SIGNATURE OF DECEASED</p>		<p>76. SIGNATURE OF WITNESSES</p>	
<p>77. SIGNATURE OF PHYSICIAN</p>		<p>78. SIGNATURE OF CORONER</p>	
<p>79. SIGNATURE OF JUDGE</p>		<p>80. SIGNATURE OF CLERK</p>	
<p>81. SIGNATURE OF NOTARY</p>		<p>82. SIGNATURE OF REGISTRAR</p>	
<p>83. SIGNATURE OF DECEASED</p>		<p>84. SIGNATURE OF WITNESSES</p>	
<p>85. SIGNATURE OF PHYSICIAN</p>		<p>86. SIGNATURE OF CORONER</p>	
<p>87. SIGNATURE OF JUDGE</p>		<p>88. SIGNATURE OF CLERK</p>	
<p>89. SIGNATURE OF NOTARY</p>		<p>90. SIGNATURE OF REGISTRAR</p>	
<p>91. SIGNATURE OF DECEASED</p>		<p>92. SIGNATURE OF WITNESSES</p>	
<p>93. SIGNATURE OF PHYSICIAN</p>		<p>94. SIGNATURE OF CORONER</p>	
<p>95. SIGNATURE OF JUDGE</p>		<p>96. SIGNATURE OF CLERK</p>	
<p>97. SIGNATURE OF NOTARY</p>		<p>98. SIGNATURE OF REGISTRAR</p>	
<p>99. SIGNATURE OF DECEASED</p>		<p>100. SIGNATURE OF WITNESSES</p>	

BUREAU V. S.

NOV 30 1956

RECEIVED

11436 CERTIFICATE OF DEATH

Reg. Dist. No.

190

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Ellicott City</u>				c. LENGTH OF STAY IN 1b <u>43 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery Road</u>				d. STREET ADDRESS <u>Montgomery Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Irene</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>17th.</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16, 1913</u>		9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Charles Theodore Weber</u>				14. MOTHER'S MAIDEN NAME <u>Alice Virginia Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Howard R. Taylor Ellicott City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>200.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer of Spinal cord - epidural</u> (c) <u>Lymphosarcoma & metastases</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1 Oct</u> 19 <u>56</u> to <u>17 Nov.</u> 19 <u>56</u> , that I last saw the deceased alive on <u>17 Nov.</u> 19 <u>56</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George E. Groleau</u> M.D.				ADDRESS (Street, city or town, state) <u>Main St Ellicott City, Md.</u>			
DATE SIGNED <u>Nov 19 1956</u>							
PHYSICIAN'S NAME (Type) <u>GEORGE E. GROLEAU</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/20/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Ellicott City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton S. S. S.</u>				ADDRESS <u>Catonsville, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov 19 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Miss L. S. S.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remail to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

11437 CERTIFICATE OF DEATH

11426

Reg. Dist. No.

191

1. PLACE OF DEATH o. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Taylor Manor Hospital</u>		d. STREET ADDRESS <u>733 Conkling St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>F.</u> Last <u>Wachter</u>		4. DATE OF DEATH Month <u>November</u> Day <u>2</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 7, 1890</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Gustave F. Tucholka</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Bauman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>George J. Wachter</u>		Address <u>:733 S. Conkling St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> <u>334x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>1 year</u> <u>not known</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with senile brain disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 19</u> , 19 <u>56</u> , to <u>Nov. 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>November 2</u> , 19 <u>56</u> , and that death occurred at <u>1130 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Irving J. Taylor</u> M.D. <u>Taylor Manor Hospital</u> <u>Nov. 2, 1956</u>			
ACTUAL SIGNATURE <u>Irving J. Taylor, M.D.</u> <u>Ellicott City, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>1401 GERMAN HILL RD., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Zeib</u>		24a. REC'D BY REGISTRAR <u>Nov 5, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>J. E. Dougherty</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

INVESTIGATION OF DEATH - BUREAU OF HEALTH

REG. NO. 100

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

BUREAU V. S.

NOV 2 1956

RECEIVED